IN THE SUPREME COURT

Appeal from the Court of Appeals
Meter, P.J., and Talbot and Borrello, J.J.

JOHANNA WOODARD, Individually and as Next Friend of **AUSTIN D. WOODARD**, a minor, and **STEVEN WOODARD**,
Plaintiffs-Appellees and Cross-Appellants

v.

JOSEPH R. CUSTER, M.D.,
Defendant-Appellant and Cross-Appellee

and

MICHAEL K. LIPSCOMB, M.D., MICHELLE M. NYPAVER, M.D., and MONA M. RISKALLA, M.D.,
Defendants.

Supreme Court No. **124994**

Court of Appeals No. 239868
Washtenaw County Circuit Court No. 99-005364-NH

JOHANNA WOODARD, Individually and as Next Friend of **AUSTIN D. WOODARD**, a minor, and **STEVEN WOODARD**,
Plaintiffs-Appellees and Cross-Appellants

v.

UNIVERSITY OF MICHIGAN MEDICAL CENTER,
Defendant-Appellant and Cross-Appellee.

Supreme Court No. **124995**

Court of Appeals No. 239869
Court of Claims No. 99-017432-CM

DEFENDANTS-CROSS-APPELLEES' BRIEF ON APPEAL

ORAL ARGUMENT REQUESTED

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STATEMENT OF BASIS OF JURISDICTION

The jurisdictional summary in plaintiffs-cross-appellants' brief is complete and correct.

This Court granted plaintiffs' cross-application for leave to appeal by an order entered on July 12, 2005.

STATEMENT OF QUESTIONS INVOLVED

WHETHER THIS COURT SHOULD AFFIRM THE HOLDING BY THE COURT OF APPEALS THAT PLAINTIFFS' PROPOSED EXPERT FAILED TO MEET THE QUALIFICATIONS IMPOSED BY MCL 600.2169(1) WHEN HE DID NOT PRACTICE OR SPECIALIZE IN EITHER PEDIATRIC CRITICAL CARE MEDICINE OR NEONATOLOGY AND WAS NOT CERTIFIED IN EITHER OF THOSE SPECIALTIES?

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STATEMENT OF FACTS

Introduction

This is a medical malpractice action. Austin Woodard, a critically ill fifteen-day-old infant, was admitted to the Pediatric Intensive Care Unit ["PICU"] at C.S. Mott Children's Hospital on January 30, 1997. Defendant Joseph Custer, M.D. was one of the attending physicians responsible for the infant's care and treatment in the PICU. Mott Children's Hospital is part of Defendant University of Michigan Medical Center.

In 1997, Dr. Custer was the director of pediatric critical care medicine at Mott and director of the University of Michigan Hospital's fellowship training program in pediatric critical care. He was certified by the American Board of Pediatrics in pediatrics, pediatric critical care medicine and neonatology-perinatology.

The trial court held that plaintiffs' proposed standard of care expert did not meet the qualifications established by MCL 600.2169(1). Anthony Casamassima, M.D. was a general pediatrician. He did not specialize or practice in pediatric critical care medicine or neonatology. He was board certified in pediatrics by the American Board of Pediatrics. He was not certified in pediatric critical care medicine or neonatology-perinatology.

The Court of Appeals, by Judges Talbot and Meter, affirmed the trial court's ruling that Dr. Casamassima was not qualified under MCL 600.2169(1). Judge Borrello dissented. This Court granted plaintiffs' cross-application for leave to appeal. 473 Mich 856, 701 NW2d 133 (2005).

Factual background

Austin Woodard was born on January 15, 1997. The infant was seen by Dr. John Kennedy, his general pediatrician, on January 29, 1997, for respiratory distress. On the following day, January 30, 1997, Austin was having "trouble breathing" and "choking" and was

"congested." His oxygen saturation was noted to be extremely poor, at 75%. His general pediatrician suspected respiratory syncytial virus (RSV) bronchiolitis, a life-threatening respiratory disease in infants. Dr. Kennedy sent Austin to the emergency room at University of Michigan Hospital by ambulance with oxygen. [Dr. Kennedy's Records – App 8a-9a, 113b]

Upon arrival at the emergency room, Austin was cyanotic and in significant respiratory distress. After being stabilized, he was transferred to the Pediatric Intensive Care Unit at Mott and seen by Dr. Custer. Shortly afterwards, he was intubated due to significant apneic events. [Interim Summary – Appx 118b] [1] The diagnosis of RSV bronchiolitis was confirmed. [Custer Dep Tr p 14 – Appx 100a] Austin was "so sick he required mechanical ventilation...and was instrumented and an artificial air hose was placed." [*Id*, p 15-16 – Apx 100a]

Austin came under the care of another PICU attending physician, Dr. Norma Maxvold, between January 30 and February 7, 1997. Dr. Maxvold specialized in pediatric critical care medicine and pediatric pulmonology. [Maxvold Dep Tr, p 5 – Appx 92b] On January 31, 1997, a right femoral line was inserted in the patient without complication. On February 2, 1997, a central venous catheter was placed in the left femoral vein, also without complication. [Answer to Complaint ¶ 27 – Appx 20b] Austin did well for the next two or three days until his respiratory status slightly worsened on February 3. His condition "continued to wax and wane over the next couple of days." His respiratory status again worsened on February 6. [Interim Summary p 2 – Appx 118b]

Dr. Custer resumed care of Austin on February 7 and saw him daily afterwards. [Custer Dep Tr p 16 – Appx 100a] The objective was to remove Austin from mechanical ventilation. [*Id* p 17 – Appx 101a] The femoral lines were removed on February 7 as charted on the pediatric

[1] Apnea is "cessation of breathing." *Dorland's Illustrated Medical Dictionary* (27th ed 1988).

intensive care unit flow sheet. [Critical Care Flowsheet – Appx 10a] As of February 9, Dr. Custer did not observe anything out of the ordinary in Austin's condition. [Custer Dep Tr p 18-19 – Appx 101a] He determined that Austin met the criteria for extubation. [Inpatient note 2/9/97 – Appx 116b] Austin came off the respirator and was extubated that day without difficulty. [Custer Dep Tr p 21 – Appx 102a]

Shortly after Austin was transferred from the PICU on February 10, 1997, he exhibited problems. His left leg became swollen and painful to touch. The suspected and later confirmed cause was deep vein thrombosis. [Inpatient notes 2/11/97 – Appx 120b-121b] An x-ray on February 11 revealed a fracture at the lower end of the left femur. A fracture of the right femur was found on February 13, per a radiology report. [Radiology reports – Appx 17a-18a] Because the fractures were consistent with potential abuse, Dr. Randall Loder, a pediatric orthopedic surgeon, and Dr. Clyde Owings, the medical director of the Child Protection Team, were consulted. [Loder Dep Tr p 10-14 – Appx 119a-120a; Owings Dep Tr p 4, 8-10 – Appx 81b-83b]

None of the physicians who examined Austin could determine the cause of the fractures. [Custer Dep Tr p 35 – Appx 105a; Loder Dep Tr p 21-27 – Appx 122a-123a] Plaintiff's proposed expert, Dr. Casamassima, could not determine "what actual procedure or what actual event caused the fracturing of the femurs." [Casamassima Dep Tr p 8 – Appx 129a]

Testimony regarding Dr. Custer's practice, specialization and certification

In 1997 when he treated Austin, Dr. Custer was the director of pediatric critical care medicine at Mott Children's Hospital. He was in charge of the physicians practicing pediatric critical care medicine in the PICU. He was also the director of the fellowship training program in pediatric critical care for the University of Michigan Medical Center. Dr. Custer is board certified in pediatrics, pediatric critical care medicine and neonatology-perinatology. He was

board certified in pediatrics in 1976 or 1977. He took the very first board in pediatric critical care medicine and was certified in 1979 or 1980. He was certified in neonatology-perinatology in 1977 or 1978. [Custer Dep Tr p 3-5 – Appx 97a-98a]

Testimony regarding Dr. Casamassima's qualifications

Since March 1998 and at the time of his deposition, Dr. Anthony Casamassima was engaged in full-time practice as an attorney with the law firm of Edelman and Edelman, P.C., in New York. He described himself as a personal injury lawyer, prosecuting medical malpractice, motor vehicle and construction cases. Between 1995 and 1998, he did independent contracting work as an attorney for that firm which included management of its medical malpractice cases. [Casamassima Dep Tr, p 56-58 – Appx 141a-142a]

Since March 1998, he has worked as a physician only two days a week at a home for mentally disabled patients ranging in age from 12 to 24. His duties were partly clinical and partly administrative. He was not the attending physician for any patients at the home. His clinical practice was in general pediatrics. [*Id*, p 59-60 – Appx 142a]

From 1993 to 1998, Dr. Casamassima was the director of medical affairs at the Richmond Children's Center, a facility for developmentally disabled children. His practice was limited to general pediatrics and medical genetics. He was not the attending physician for any patients. None of his practice involved pediatric critical care medicine. The center did not have a pediatric intensive care unit. [*Id* p 63-65 – Appx 143a-144a] From 1986 to 1991, Dr. Casamassima was the associate director medical genetics at the New York Medical College. The majority of his practice was devoted to genetics. [*Id* p 62-63 – Appx 143a] He has published eighteen articles. Seventeen deal with medical genetics. The other article is entitled "Spoliation

of Evidence in Medical Malpractice" and was not published in a medical journal. [*Id* p 67-67 – Appx 144a]

In the year preceding the alleged malpractice in this case, Dr. Casamassima's professional practice was limited to general pediatrics on an outpatient basis. [*Id* p 82 – Appx 148a] He received board certification in pediatrics in 1982. [*Id* p 67 – Appx 144a]

Dr. Cassamassima has no experience or training as an attending physician in a pediatric intensive care unit. [*Id* p 69 – Appx 145a] He was not familiar with any authoritative texts in critical care medicine. [*Id* p 99 – Appx 152a] He has not placed an arterial or venous line since his residency and has not intubated a patient since the early 1980's. [*Id* p 99-100 – Appx 152a]

Procedural background in the trial court

On October 4, 1999, plaintiffs filed their complaint against the Regents of the University of Michigan in the Court of Claims. [Complaint – Appx 24a-38a] On October 7, 1999, plaintiffs filed a complaint in Washtenaw County Circuit Court naming Joseph R. Custer, M.D., Michael K. Lipscomb, M.D., Michele M. Nypaver, M.D. and Mona M. Riskalla, M.D. as defendants.[2] [Complaint – Appx 44a-59a] Both complaints were accompanied by an affidavit of merit signed by Dr. Casamassima. [Affidavits of Merit – Appx 39a-43a, 60a-64a] The cases were consolidated before Washtenaw Circuit Court Judge Timothy P. Connors.

The complaints and affidavits of merit related to purported breaches of the standard of care by Dr. Custer and other physicians and staff in the PICU, including alleged failures to:

> • "Properly treat and monitor the infant Plaintiff with the degree of care required so as not to fracture Plaintiff's bones during insertion of arterial lines and femoral venous lines";

[2] All of the individual defendants, except Dr. Custer, were dismissed by stipulation.

> • "Properly treat the infant Plaintiff with the degree of care required in the insertion of an arterial line so as not to subject Plaintiff to a loss of blood requiring transfusion";
>
> • "Properly monitor the infant Plaintiff after placement of a femoral venous line and allowing him to lay on one side for over an hour subjecting Plaintiff to swelling and deep vein thrombosis..."; and
>
> • "Properly monitor the infant Plaintiff after placement of a femoral venous line and arterial line, and after undergoing a blood transfusion, to prevent the onset of line sepsis, subsequent bacterial endocarditis and resultant septic emboli causing multiple cerebral infarctions." [Affidavit of merit p 3-4 – Appx 62a-63a]

On February 10, 2000, defendants filed their answer and a motion for summary disposition. The motion asserted, *inter alia*, that plaintiffs' counsel could not reasonably believe that Dr. Casamassima was qualified as an expert witness under MCL 600.2169, and therefore, the affidavit of merit did not meet the requirements of MCL 600.2912d(1). [Motion for summary disposition ¶ 9 – Appx 36b-37b] The trial court denied the motion, concluding that the affidavit was sufficient under MCL 600.2912d because plaintiffs' counsel reasonably believed that the affiant was qualified since he "share[d] a board certified specialization in pediatrics" with Dr. Custer and the other defendant physicians. The trial court stated that the ruling only applied to the affidavit of merit and that Dr. Casamassima's qualifications to testify at trial would be considered at a later time. [Motion Tr 3/21/00 p 12-13 – Appx 76a-77a]

A voluminous amount of discovery was undertaken in the ensuing year and a half. Dr. Custer and a large number of physicians involved in Austin Woodard's care and treatment were deposed. Dr. Casamassima was deposed on August 10, 2001. [Casamassima Dep – Appx 128a-160a] He was the only non-treating expert identified on plaintiffs' witness list. [Plaintiffs' Witness List – Appx 68b]

After the close of discovery, defendants filed a Motion to Strike Dr. Casamassima as an Unqualified Expert. [Motion to strike – Appx 70b-79b] The motion was heard on September 14, 2001. Defendants asserted that the Legislature, while not pondering distinct and fine gradations between specialties and subspecialties in MCL 600.2169, clearly intended to "keep those who don't know what they are talking about from criticizing those in another field." Defendants argued that Dr. Casamassima had not set foot in any hospital for many years, let alone a hospital containing a pediatric intensive care unit. Rather, he practiced general pediatrics in a small facility for developmentally disabled youngsters. Defendants contended that Dr. Casamassima lacked any experience which provided a basis to offer expert testimony regarding the placement of central lines into the tiny vessels of a two-week-old infant or the proper manner of intubating a newborn. [Motion Tr 9/14/01 p 14-16 – Appx 174a-176a]

Plaintiffs argued that *res ipsa loquitur* applied based upon circumstantial evidence, *i.e.*, that there was no indication that Austin had femoral fractures and that fractures were discovered after his transfer from the PICU. Plaintiffs acknowledged that they could not establish that the fractures were caused by any particular actions by Dr. Custer or other PICU staff. They asserted that Dr. Casamassima was "certainly qualified" to testify that "you don't have three fractures on a 15 week old [*sic* – should be "15-day-old"] infant in the first two weeks of its admission in the hospital." [*Id* p 18-23 – Appx 178a-183a]

The trial court made the following findings of facts regarding Dr. Casamassima's qualifications:

> • Between December 1993 and March of 1998, none of Dr. Casamassima's clinical practice involved pediatric critical care medicine;
>
> • Dr. Casamassima has no experience or training as an attending physician in a pediatric intensive care unit;

> • The last time he performed an intubation or placement of a central line was during his residency in the early 1980s;
>
> • He became a full-time lawyer in March of 1998; and
>
> • His pediatric practice contains approximately two days per week in the context of a home for mentally disabled children, in which he performs no work as an attending physician responsible for patient care. [*Id* p 30-31 – Appx 190a-191a]

The trial court concluded that Dr. Casamassima was not qualified to testify under MCL 600.2169 because he "did not devote a majority of his time within the year preceding the injury to the same active clinical specialty as Dr. Custer or the staff of the pediatric intensive care unit" [*Id* p 31-32 – Appx 191a-192a]

Decision of the Court of Appeals

In an opinion authored by Judge Talbot and concurred in by Judge Meter, the Court of Appeals held that the trial court did not err by ruling that Dr. Casamassima was not qualified as an expert witness under MCL 600.2169. [Opinion (Talbot, J.) p 6; Opinion (Meter, J.) p 2 – Appx 234a, 239a] The majority rejected plaintiff's "claim that their theory of the case is not grounded in pediatric critical care but in general pediatric medicine" and therefore, Dr. Casamassima was qualified as a board certified general pediatrician. The opinion stated that:

> ... plaintiffs were unable to establish that the fractures were caused by the manner in which the infant was "handled and maneuvered" at the PICU. It was disputed whether the fractures occurred during the infant's stay at the PICU and whether the injuries resulted from a pathological cause or child abuse. Accordingly, plaintiff's claim that the fractures were caused by the mere "handling and maneuvering" of the infant during its stay at the PICU is without merit.
>
> Moreover, plaintiffs have not established that the medical standard of care for an inpatient intensive care unit for critically ill infants is the same as that for general pediatric medicine. It appears from the record that it is not. Plaintiffs' own expert witness, Dr.

> Casamassima, testified that a number of procedures that were performed on the infant at the PICU had the potential to cause fractures to the legs. He did not assert that those procedures were normally practiced in general pediatrics or that the standard of care for the treatment of critically ill infants was the same as that for general pediatric practice....Accordingly, plaintiffs' theory of the case was grounded not in general pediatric treatment but in pediatric intensive care. [Opinion (Talbot, J.) p 5 – Appx 233a]

The majority found that "Dr. Casamassima's clinical practice during the year immediately preceding the instant injury, § 2169(1)(b), did not involve pediatric critical care medicine" and that he " that he was unaware of the precise standard of care for the treatment of critically ill infants." [*Id*] After discussing plaintiffs' argument based on *Tate v Detroit Receiving Hosp,* 249 Mich App 212, 642 NW2d 346 (2002), the majority concluded:

> Insofar as the trial court determined that Dr. Casamassima was required to possess the same subspecialties as Dr. Custer and the physicians who treated the infant at the PICU, such ruling was erroneous, but harmless. Therefore, the trial court did not abuse its discretion when it determined that Dr. Casamassima did not meet the qualifications requirements set forth in § 2169(1)(a), because he did not possess board certification in pediatric critical care medicine. [*Id* p 6 – Appx 234a]

Judge Borrello dissented from this holding. [Opinion (Borrello, J.) p 2-4 – Appx 241a-243a]

In separate opinions, Judges Borrello and Meter ruled that expert testimony was not required under the doctrine of *res ipsa loquitur.* [Opinion (Borrello, J.) p 4-6; Opinion (Meter, J.) p 2 – Appx 243a-245a, 239a] That holding was reversed by this Court. 473 Mich 1, 702 NW2d 522 (2005).

ARGUMENT

Introduction

This malpractice action involves the care of a critically ill fifteen-day-old infant. The treatment occurred in the pediatric intensive care unit of Mott Children's Hospital. At that time, Dr. Custer was the director of pediatric critical care medicine. He was also the director of the University of Michigan Hospital's fellowship training program in pediatric critical care and was in charge of the physicians who work in the pediatric care unit. He has been and continues to be certified by the American Board of Pediatrics in pediatrics, pediatric critical care medicine and neonatology-perinatology.

Dr. Custer was one of the attending physicians responsible for the care and treatment of Austin Woodard while the infant was in the pediatric intensive care unit. He supervised the four fellows in pediatric critical care medicine who were involved in the care of this critically ill newborn.

Plaintiffs' proposed expert witness, Dr. Anthony Casamassima, is certified in pediatrics by the American Board of Pediatrics. His clinical practice has been limited to general pediatrics. He has no experience or training as an attending physician in a pediatric intensive care unit. He does not specialize in either pediatric critical care medicine or neonatology and is not certified in either field.

The trial court and the Court of Appeals correctly held that Dr. Casamassima is not qualified to give expert testimony on the standard of care under MCL 600.2169(1). He fails to meet the requirements of either subsection (1)(a) or (1)(b) of the statute.

In *Halloran v Bhan,* 470 Mich 572, 578-579, 683 NW2d 129 (2004), this Court held that MCL 600.2169(1)(a) imposes two specific and separate requirements for qualifying an expert witness in an action alleging medical malpractice. First, "[i]f the party against whom or on

whose behalf the testimony is offered is a *specialist*," then the proposed expert must be a licensed health professional who "*specializes* at the time of the occurrence that is the basis for the action *in the same specialty* as the party." Second and additionally, if the party "is a *specialist* who is *board certified*," then "the expert witness must be a *specialist who is board certified in that specialty.*"

MCL 600.2169(1)(b) imposes another requirement. If the party "is a *specialist*," the proposed expert must have "devoted a majority of his or her professional time" during the year immediately preceding the date of the occurrence that is the basis for the claim or act to either or both of "the active clinical practice of that *specialty*" or "the instruction of students...in the same *specialty*."

This appeal involves the correct interpretation of the key terms used in MCL 600.2169(1). This Court has directed the parties to address the following issues:

> (1) What are the appropriate definitions of the terms "specialty" and "board certified" as used in MCL 600.2169(1);
>
> (2) Whether either "specialty" or "board certified" includes subspecialties or certificates of special qualifications;
>
> (3) Whether MCL 600.2169(1)(b) requires an expert witness to practice or teach the same subspecialty as the defendant;
>
> (4) Whether MCL 600.2169(1) requires an expert witness to match all specialties, subspecialties, and certificates of special qualifications that a defendant may possess, or whether the expert witness need only match those that are relevant to the alleged act of malpractice; and
>
> (5) What are the relevant specialties, subspecialties, and certificates of special qualifications in this case.

Defendants contend that the term "specialty" should be given its commonly understood meaning as an area of medical practice focused on a particular class of diseases, conditions or

patients. Dr. Custer has concentrated his professional career on the treatment of critically ill infants and children. His specialties are pediatric critical care medicine and neonatology-perinatology.[3] Defendants also submit that "board certified" should be interpreted according to its dictionary definition as "officially certified as expert in a particular field after passing an exam and meeting strict standards."[4] Dr. Custer has met the rigorous standards and requirements of the American Board of Pediatrics and has been certified by that board in pediatric critical care medicine and neonatology-perinatology.

Plaintiffs and the Michigan Trial Lawyers Association maintain that the statutory terms must be interpreted according to the designations employed by the American Board of Medical Specialties ["ABMS"] and the American Osteopathic Association ["AOA"]. According to this argument, a physician is only a specialist if his or her area of practice has been classified as a primary specialty by the ABMS and AOA, *i.e.,* "specialty" means only those "areas of medical practice capable of being board certified." [Appellants' Brief, p 31] Upon that foundation, plaintiffs and MTLA construct an elaborate rewrite of the statute that would replace the word "specialty" with the phrase "the board certified primary specialties recognized by the ABMS and AOA."

As discussed in Argument I(B), *infra*, such an interpretation is contrary to the commonly understood meaning of the words used by the Legislature. Moreover, it is inconsistent with the legislative intent to ensure that expert witnesses have "firsthand practice experience in the subject matter about which they are testifying." *McDougall v Schanz*, 461 Mich 15, 25 n 9, 597

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[3] Neonatology is "the study of the development and disorders of newborn children." *Random House Webster's College Dictionary* (2001). Perinatology is "a medical specialty concerned with the care and treatment of mother and infant immediately prior to, during, and following childbirth." *Encarta World English Dictionary* (1999)

[4] *Encarta World English Dictionary* (1999)

NW2d 148 (1999). Rewriting the statute in that manner would also lead to absurd results, in which physicians who engage in identical specialized practices could be general practitioners, specialists or subspecialists depending on whether they trained in allopathic or osteopathic medicine.

Once the plain meaning of "specialty" and "board certified" are applied, the classifications of practice areas as primary specialties or subspecialties by the ABMS, AOA and other professional associations are not germane. In this case, plaintiffs were required to present an expert witness with the requisite experience, qualifications and certification in the specialties of pediatric critical care medicine and neonatology. Their proposed witness failed to satisfy *any* of the requirements in MCL 600.2169(1).

STANDARD OF REVIEW

Questions of statutory interpretation are reviewed *de novo*. *Halloran, supra*, 470 Mich at 575. After the correct legal standard is established, a trial court's determination as to whether a witness is qualified to provide expert testimony is reviewed for an abuse of discretion. *Bahr v Harper-Grace Hospitals*, 448 Mich 135, 141, 528 NW2d 170 (1995); *Cox ex rel Cox v Board of Hosp Managers for City of Flint*, 467 Mich 1, 16 n 16, 651 NW2d 356 (2002). This standard of review applies to each of the issues presented in this appeal.

PRINCIPLES OF STATUTORY CONSTRUCTION

The correct approach for interpreting statutory language has been firmly established in recent decisions. In *Burton v Reed City Hosp Corp,* 471 Mich 745, 751, 691 NW2d 424 (2005), the first and foremost rule was summarized:

> The cardinal principle of statutory construction is that courts must give effect to legislative intent. *Morales v Auto-Owners Ins Co (After Remand)*, 469 Mich 487, 490, 672 NW2d 849 (2003). When reviewing a statute, courts necessarily must first examine the

> text of the statute. *Dressel v Ameribank*, 468 Mich 557, 562, 664 NW2d 151 (2003). If the Legislature's intent is clearly expressed by the language of the statute, no further construction is permitted. *Helder v Sruba*, 462 Mich 92, 99, 611 NW2d 309 (2000).

"Undefined statutory terms must be given their plain and ordinary meanings, and it is proper to consult a dictionary for definitions." *Halloran, supra,* 470 Mich at 578. This principle was further explained in *In re Certified Question from United States Court of Appeals for Sixth Circuit*, 468 Mich 109, 113, 659 NW2d 597 (2003).

> Where the Legislature has not expressly defined the common terms used in a statute, this Court may turn to dictionary definitions "to aid our goal of construing those terms in accordance with their ordinary and generally accepted meanings." *People v Morey*, 461 Mich 325, 330, 603 NW2d 250 (1999).
>
> The statutory language must be read and understood in its grammatical context, unless it is clear that something different was intended. *Sun Valley Foods Co. v. Ward*, 460 Mich 230, 596 NW2d 119 (1999).

When reference to dictionary definitions does not provide a clear understanding of the statutory term, the interpretation proceeds to the next stage, as stated in *Roberts v Mecosta Co General Hosp,* 470 Mich 679, 706, 684 NW2d 711 (2004):

> Thus, to determine what the statute intends, we examine its structure as a whole, and particularly, the text surrounding the word "statement." *G.C. Timmis & Co. v Guardian Alarm Co*, 468 Mich 416, 420, 662 NW2d 710 (2003).
>
> In discerning the intended meaning, we consider also the Legislature's apparent purpose in enacting the provision. *In re Wirsing*, 456 Mich 467, 474, 573 NW2d 51 (1998). We may even consider legislative history. *Adrian School Dist v Michigan Pub School Employees Retirement Sys*, 458 Mich 326, 335, 582 NW2d 767 (1998).

Legislative history can only be consulted "where a genuine ambiguity exists in the statute." *In re Certified Question, supra,* 468 Mich at 115 n 5. Even in that setting, legislative

history must be used cautiously. *Office Planning Group, Inc v Baraga-Houghton-Keweenaw Child Development Bd*, 472 Mich 479 n 28 (2005); *Frank W Lynch & Co v Flex Technologies, Inc*, 463 Mich 578, 587 n 7, 624 NW2d 180 (2001).

I. A "SPECIALTY" IS AN AREA OF MEDICAL PRACTICE FOCUSED ON THE TREATMENT OF A PARTICULAR CLASS OF DISEASES, CONDITIONS OR PATIENTS. PEDIATRIC CRITICAL CARE MEDICINE AND NEONATOLOGY-PERINATOLOGY ARE SPECIALTIES WITHIN THE COMMON UNDERSTANDING OF THE TERM USED IN MCL 600.2169(1).

The first sentence of MCL 600.2169(1)(a) employs three related terms. If the party is a "specialist," then the proposed expert must "specialize" in the same "specialty." The common understanding of these terms involves the concentration of a physician's practice on the treatment of a particular class of conditions, diseases or patients.[5] Applying this definition, Dr. Custer is a "specialist" in the "specialties" of pediatric critical care medicine and neonatology-perinatology.

This Court has already interpreted the term "specialist" when used in the statute defining the standard of care in malpractice actions. In *Cox ex rel Cox v Board of Hosp Managers for City of Flint*, 467 Mich 1, 651 NW2d 356 (2002), the issue was "whether nurses are held to the standard of care of a general practitioner or specialist under MCL 600.2912a." Holding that the statute did not apply to nurses, this Court relied on the generally accepted meanings of "general practitioner" and "specialist."

> *Random House Webster's College Dictionary (1997)* defines "general practitioner" as "a medical practitioner whose practice is not limited to any specific branch of medicine." *"Specialist" is defined as "a medical practitioner who deals only with a*

[5] The shared root of these terms, *i.e.*, "special," is defined as "of a distinct or particular kind or character" and "pertaining or peculiar to a particular person, thing, instance, etc.; distinctive." *Random House Webster's College Dictionary* (2001).

> *particular class of diseases, conditions, patients, etc." Id* at 18 (emphasis added)

See also, *Decker v Flood*, 248 Mich App 75, 83, 638 NW2d 163, 167 (2002)(applying same definition); *McQuire v Wasvary,* unpublished opinion *per curiam* of the Court of Appeals, decided Jan. 25, 2005 (Docket No. 248309).

The definition of "specialist" adopted in *Cox* is consistent with other lay and medical dictionaries. *The Oxford English Dictionary* (1989)("A medical practitioner or authority who specifically devotes his attention to the study or treatment of a particular disease or class of diseases."); *Stedman*'s *Medical Dictionary* (27th ed 2000)("One who has developed professional expertise in a *particular specialty or subject area.*" (emphasis added)).

The term "specialty" logically carries forward the same fundamental meaning, since a specialty is "something in which one specializes or of which someone has special knowledge." *Webster's Third New International Dictionary* (1976). "Specialty" is defined as "a special subject of study, line of work, skill, or the like on which one concentrates." *Random House Webster's College Dictionary* (2001). Other definitions are similar, referring to a "specialty" as a "special interest, field of study or professional work," *Webster's New World Dictionary* (1988), and a "pursuit, area of study, or skill to which someone has devoted themselves and in which they are expert." *Compact Oxford English Dictionary* (2005).

More specifically applied to the medical profession, a "specialty" is "[a] branch of medicine or surgery, such as cardiology or neurosurgery, in which a physician specializes," *The American Heritage Dictionary of the English Language* (2000), or "[t]he particular subject area or branch of medical science to which one devotes professional attention." *Stedman's Medical Dictionary* (27th ed 2000).

A. Pediatric critical care medicine and neonatology-perinatology are "specialties" within MCL 600.2169(1).

Applying the common understanding of the statutory language, Dr. Custer is a "specialist" in the "specialties" of pediatric critical care medicine and neonatology-perinatology. For a quarter century, he has "specifically devote[d] professional attention" to and "developed professional expertise" in the care and treatment of a "particular class" of patients and conditions, *i.e.,* newborns and infants who are critically ill. He has been the director of pediatric critical care medicine for the University of Michigan's Mott Children's Hospital since 1985. He received his board certification in pediatric critical care medicine in 1979 or 1980, which was the first occasion that such certification was available. He was certified in neonatal-perinatal medicine in 1977 or 1978. He has been recertified every seven years. Dr. Custer was the director of the fellowship training program in pediatric critical care and in charge of the physicians who work in the pediatric intensive care unit. [Custer Dep, p 4-5; Appx 97a-98a] He was an attending physician responsible for the care and treatment of Austin Woodard while the infant was in the pediatric intensive care unit. Dr. Custer supervised the four fellows in pediatric critical care medicine who were involved in the care of this critically ill newborn. [*Id* p 5-7, 73, Appx 98a, 115a]

If an ordinary person were asked whether a physician with extensive training, experience and expertise in the care of critically ill infants has a "specialty," the answer would undoubtedly be "yes." The Legislature is presumed to have intended the plain and common understanding of the statutory terms in MCL 600.2169(1)(a).

B. The designation of practice areas as specialties or subspecialties by the American Board of Medical Specialties or the American Osteopathic Association should not substitute for the common understanding of the statutory terms.

Plaintiff and MTLA assert that the statutory language requires wholesale adoption of the designation of primary specialties by the American Board of Medical Specialties ["ABMS"] and the American Osteopathic Association ["AOA"].[6] Such an interpretation would violate the basic principle of construction which prohibits a court from "judicially legislat[ing] by adding language to the statute. *Empire Iron Mining Partnership v Orhanen*, 455 Mich 410, 421, 565 NW2d 844 (1997); *Roberts v Mecosta Co Gen Hosp*, 466 Mich 57, 63, 642 NW2d 663 (2002); *AFSCME v Detroit*, 468 Mich 388, 400, 662 NW2d 695 (2003).

This interpretation is inconsistent with the ordinary dictionary definition of "specialty" which includes areas of practice that the ABMS and AOA classify as subspecialties. "Specialty" is defined as "[a] branch of medicine or surgery, such as *cardiology* or neurosurgery, in which a physician specializes; the field or practice of a specialist." In turn, a "specialist" is defined as "[a] physician whose practice is limited to a particular branch of medicine or surgery, especially one who is certified by a board of physicians: *a specialist in oncology*." *The American Heritage Dictionary of the English Language* (2000)(emphasis added) The examples used to demonstrate the meaning of "specialty" and "specialist" refer to physicians specializing in cardiology and oncology. Neither the ABMS nor AOA classify cardiology or oncology as a specialty, but instead as subspecialties of internal medicine.[7]

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[6] Actually, MTLA would only apply the statutory term to specialties that are board certified by the ABMS. [MTLA Amicus Brief, p 23] The curious and unexplained omission of AOA board certified specialties would further compound the problems inherent in plaintiff's and MTLA's interpretation which are discussed in the text.

[7] ABMS *Member Board Specialty and Subspecialty Certificates 2005* [Exhibit 1]; AOA *Specialties/Subspecialties* [Exhibit 2]

When using "specialist" and "specialty" in the first sentence of MCL 600.2169(1), the Legislature did not use any language limiting those terms to the classifications of practice areas by professional boards or organizations. In contrast, a number of other statutes specifically refer to such entities when defining the qualifications for physicians in different contexts.[8] The Legislature plainly knew how to include references to the ABMS and AOA, as well as other comparable professional associations, in statutes imposing qualifications for physicians. The omission of any such language in MCL 600.2169(1) demonstrates that the Legislature did not intend the meaning asserted by plaintiffs and MTLA. *Farrington v Total Petroleum, Inc*, 442 Mich 201, 210, 501 NW2d 76 (1993) ("Courts cannot assume that the Legislature inadvertently omitted from one statute the language that it placed in another statute, and then, on the basis of that assumption, apply what is not there.")

A comparison to New Jersey's statute regarding qualification of expert witnesses in malpractice actions is instructive. The New Jersey statute contains matching specialty, board certification and clinical practice requirements that parallel Michigan's statute. However, there is a critical difference in the language defining the requirements. NJSA 2A:53A-41a provides:

> a. *If the party* against whom or on whose behalf the testimony is offered *is a specialist or subspecialist recognized by the American Board of Medical Specialties or the American Osteopathic Association* and the care or treatment at issue involves that specialty or subspecialty recognized by the American Board of Medical Specialties or the American Osteopathic Association, *the person providing the testimony shall have specialized* at the time of

[8] See, *e.g.* MCL 550.1402a(4)(reference to ABMS or "other national health professional organization"); MCL 550.2212a(4)(same); MCL 333.1100a (AOA and Accreditation Council for Graduate Medical Education); MCL 550.1919(2)(c)("recognized American medical specialty board"); MCL 333.20918(3)(board certified by "national organization approved by the department"); MCL 333.17020(3) (physician board certified by the American Board of Medical Genetics and "appropriate professional organizations"); MCL 333.17520(3)(same); MCL 333.16204a(1)(a)("national organizations approved by the department of consumer and industry services," including the ABMS and American Board of Pain Medicine).

> the occurrence that is the basis for the action *in the same specialty or subspecialty, recognized by the American Board of Medical Specialties or the American Osteopathic Association*, as the party against whom or on whose behalf the testimony is offered... (emphasis added)[9]

Unlike the New Jersey statute, MCL 600.2169(1) simply does not contain the language that plaintiffs and MTLA want this Court to judicially enact, *i.e.,* a specialty "recognized by the American Board of Medical Specialties or the American Osteopathic Association."

There are other problems with this interpretation besides the lack of statutory language. Plaintiffs and MTLA fail to explain how a court should address the differing number of specialties designated by various organizations. The ABMS designates certain fields of medical practice as specialties while the AOA does not, and *vice versa*. The ABMS has 24 member boards; the AOA only has 18. The ABMS member boards award 36 primary specialty certificates; the AOA boards have issued as many as 39 general specialty certifications, 5 of which are no longer available.[10]

A few examples demonstrate the inescapable problems with rewriting the statute to define "specialty" as a "specialty recognized by the ABMS or AOA." Assume that a malpractice action is brought against an osteopathic physician specializing in immunology. The AOA does not have a specialty board in that field. Instead, a certificate of special qualifications in the subspecialty of immunology is issued by the American College of Osteopathic Internists. In

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[9] The full text of NJSA 2A:53A-41a is attached as Exhibit 3.

[10] ABMS *Member Board Specialty and Subspecialty Certificates 2005* [Exhibit 1]; AOA *Specialties/Subspecialties* [Exhibit 2]

The problems with this approach are evident from plaintiffs' and MTLA's briefs which confuse the number of member boards and primary specialties. Both plaintiffs and MTLA state that the ABMS only recognizes 24 specialties. [Appellants' Brief, p 29, 33, 36; MTLA's Brief, p 11, 13]

contrast, the American Board of Allergy and Immunology is a member board of ABMS and awards a primary specialty certificate in that field. [11] Under the approach that plaintiffs and MTLA advocate, an osteopathic immunologist would not be a specialist while an allopathic physician in the same field would be. In a malpractice action against the osteopathic physician, the expert would only have to be a specialist in internal medicine. Yet, if the same allegations involved an allopathic immunologist, only a specialist in that specific area of practice could testify.

A similar anomaly would exist in an action against an osteopathic surgeon who has limited his or her practice to colon and rectal surgery. The AOA does not recognize that practice as *either* a specialty or subspecialty, while the ABMS designates it as a primary specialty.[12] According to plaintiffs, the osteopathic colon and rectal surgeon would be a general practitioner and not a specialist. In a suit against that highly specialized surgeon, a general practitioner could be qualified as an expert witness. If the defendant was an allopathic colon and rectal surgeon, the expert would be required to specialize in that field.

These absurd results would not be visited only upon osteopathic physicians. Proctology is a primary AOA specialty. Under the ABMS designations, it is neither a specialty nor a subspecialty.[13] Plaintiffs and MTLA would treat an allopathic proctologist as a general practitioner.

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[11] American College of Osteopathic Internists, *Certification* [Exhibit 4]; ABMS *Member Board Specialty and Subspecialty Certificates 2005* [Exhibit 1]

[12] AOA *Specialties/Subspecialties* [Exhibit 2]; ABMS *Member Board Specialty and Subspecialty Certificates 2005* [Exhibit 1]

[13] *Id.*

As discussed in Argument I(A), *supra*, the generally accepted definitions of "specialty" and "specialist" are not ambiguous. However, even if the terms are considered ambiguous, MCL 600.2169(1) should not be construed in a manner which would lead to such absurd and unworkable results. *Gilbert v Second Injury Fund*, 463 Mich 866, 867, 616 NW2d 161 (2000). Two physicians providing the same specialized care to the same limited class of patients would be treated differently. One would be a general practitioner while the other would be a specialist, depending on whether they held an M.D. or D.O. degree. Some specialty certificates are no longer available through the ABMS.[14] Under plaintiffs' and MTLA's reading of the statute, a physician would stop being a specialist if the ABMS chose to no longer issue primary certification in that practice area. In March 2005, the ABMS approved an application from the American Board of Surgery for authorization to issue a primary certificate in vascular surgery which would replace the prior subspecialty certificate.[15] Vascular surgeons are "specialists" because they have devoted years of training and experience to gain specialized expertise in that particular area of surgical practice. These physicians did not become "specialists" solely because the ABMS approved issuance of a primary certificate.

Even the ABMS does not enforce any strict delineation between specialists and subspecialists. The ABMS remarks that after passing the subspecialty certification examination, a "medical oncologist specializes in and confines his/her practice to the diagnosis and treatment of cancer."[16] On the ABMS website which allows the public to search for certified physicians,

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[14] 2005 ABMS *Annual Report and Reference Handbook*, Footnotes to Table 1, p 78 n 4 [Exhibit 5]

[15] *Id* p 78 n 7

[16] ABMS, *What is a Subspecialist?* [Exhibit 6]

the "search by specialty" and "area of specialty" tabs include all of the primary specialties and subspecialties.[17]

There is an additional reason to reject plaintiffs' and MTLA's proposed interpretation. No language, either in MCL 600.2169(1) or any other Michigan statute, supports the assertion that *only* ABMS and AOA have the authority to determine which areas of medical practice are specialties. Other well-respected and long-established professional organizations examine the training and qualifications of physicians and certify their expertise in specialized areas of practice. For example, the American Board of Pain Medicine issues certificates to physicians who have demonstrated their qualifications in that field.[18] However, the ABPM is not a member board of either the ABMS or AOA. The ABMS and AOA treat pain medicine as a subspecialty of anesthesiology. The ABMS also recognizes it as a subspecialty of physical medicine and rehabilitation, psychiatry and neurology.[19]

A statute dealing with pain medicine further demonstrates that the Legislature did not intend the term "specialty" to be defined by reference to the designations employed by the ABMS and AOA. MCL 333.16204a establishes an advisory committee on pain and symptom management within the Department of Community Health. One member of the committee must be "a physician *certified in the specialty of pain medicine* by 1 or more national professional organizations . . . including, but not limited to, the American board of medical specialists or the American board of pain medicine." MCL 333.16204a(1)(a)(emphasis added). Similarly, MCL

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[17] ABMS, *Who's Certified?* [Exhibit 8]

[18] The American Board of Pain Medicine has certified 1,898 physicians as of February 2005. ABPM *FAQ's* [Exhibit 8]

[19] ABMS *Member Board Specialty and Subspecialty Certificates* 2005 [Exhibit 1]; AOA *Specialties/Subspecialties* [Exhibit 2]

550.1402a(2)(b) & (4) and MCL 550.2212a(2)(b) & (4) refer to health professionals who are "*board certified* in the *specialty* of pain medicine" by the ABMS or "another appropriate national health organization." (emphasis added) Thus, the Legislature has treated pain medicine as a "specialty" which can be "board certified" despite its classification as a subspecialty by the ABMS and AOA.[20]

The Legislature can constitutionally enact statutes that impose legal consequences based on "factual conclusions of independent significance" by other public or private bodies. *Taylor v Smithkline Beecham Corp*, 468 Mich 1, 17-19, 658 NW2d 127 (2003). However, a court should not judicially create such a "referral statute" in the absence of any language suggesting that the Legislature intended to do so.

Rather than becoming entangled in the conflicting designations of specialties and subspecialties by the ABMS and AOA (and perhaps other professional associations as well), the plain language of the statutory terms should be followed. This Court has concluded already that a specialist is "a medical practitioner who deals only with a particular class of diseases, conditions, patients, etc." *Cox, supra,* 467 Mich at 18. Pediatric critical care medicine and neonatology-perinatology fall squarely within that definition.

C. Applying the common understanding of the term "specialty" is consistent with the legislative purpose of MCL 600.2169(1).

The primary goal of statutory construction, of course, is to give effect to the intent of the Legislature. *Nastal v Henderson & Associates Investigations, Inc*, 471 Mich 712, 720, 691 NW2d 1 (2005). Defining "specialty" according to its generally accepted meaning furthers the legislative purpose of MCL 600.2169(1).

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[20] See also, MCL 330.1948b ("specialty of child psychiatry"). The American Board of Psychiatry and Neurology issues a subspecialty certificate in child psychiatry. ABPN, *Certification – Subspecialty Certificates for Diplomates in Psychiatry*. [Exhibit 9]

In *McDougall v Schanz*, 461 Mich 15, 25 n 9, 597 NW2d 148 (1999), this Court referred to the *Report of the Senate Committee on Civil Justice Reform*, which stated that the statute was intended "to make sure that experts will have *firsthand practical expertise* in the subject matter about which they are testifying" and "to insure that in malpractice suits against specialists the expert witnesses *actually practice* in the same speciality [*sic*]." (emphasis added) The goal of requiring experts to have "firsthand practical experience" is best accomplished by applying the common definition of "specialty" as "a special subject of study or research; that branch of scholarly, scientific or professional work in which one is a specialist." *The Oxford English Dictionary* (1989). When the dispositive medical issues in a malpractice action relate to the specialized treatment of critically ill infants, the trier of fact should be reliably informed about the applicable standard of care by experts with practical experience in pediatric critical care medicine and neonatology.

The interpretation proposed by plaintiffs and MTLA would perpetuate the very problems that the Legislature sought to remedy. The ABMS and AOA both classify internal medicine as a primary specialty. Subspecialty certifications are awarded in cardiovascular disease, gastroenterology, hematology, oncology, pulmonary disease, sleep medicine and several other areas of practice.[21] If the ABMS and AOA designations are judicially grafted onto MCL 600.2169(1), a gastroenterologist could testify that a cardiologist breached the standard of care when diagnosing and treating heart disease, simply because both fields are classified as subspecialties of internal medicine. The Legislature certainly did not intend that a sleep

[21] ABMS *Member Board Specialty and Subspecialty Certificates 2005* [Exhibit 1]; AOA Specialties/Subspecialties [Exhibit 2]; American Board of Internal Medicine, *Policies and Procedures for Certification 2005*, p 6-8 [Exhibit 10]

medicine physician would be qualified to testify that an oncologist failed to properly treat a cancer patient or that a nephrologist properly diagnosed kidney disease.

D. The terms "specialist" and "specialty" in MCL 600.2169(1) should be interpreted consistently with the same terms in MCL 600.2912a(1).

In a closely related statute, the Legislature has used the same terms, *i.e.,* "specialist" and "specialty." MCL 600.2912a(1) provides that "in an action alleging malpractice, the plaintiff has the burden of proving that in light of the state of the art existing at the time of the alleged malpractice":

> (b) The defendant, *if a specialist*, failed to provide the *recognized standard of practice or care within that specialty* as reasonably applied in light of the facilities available in the community or other facilities reasonably available under the circumstances, and as a proximate result of the defendant failing to provide that standard, the plaintiff suffered an injury. (emphasis added)

As discussed previously, this Court has already employed the common dictionary definition of "specialist" in MCL 600.2912a(1). *Cox, supra,* 467 Mich at 18. Statutes sharing a common purpose or relating to the same subject should be construed together if necessary to discern the meaning of ambiguous language. *Omne Financial, Inc v Shacks, Inc*, 460 Mich 305, 312, 596 NW2d 591 (1999). The same definitions should apply to the same terms used in MCL 600.2169(1).

Plaintiffs and MTLA rely on other statutes dealing with different subjects to suggest that the term "specialty" should be redefined as "specialty capable of being board certified by the ABMS or AOA." However, these statutes are not *in pari materia* and offer no basis for abandoning the common understanding of the language in MCL 600.2169(1). For example, MTLA relies on the definition of "academic institution" in the Public Health Code, which includes a hospital with residency programs "in the specialty area of medical practice, or in a specialty area that included the subspecialty of medical practice" in which an applicant for a

limited license proposes to practice. MCL 333.17001(1)(a)(ii)(A). This definition is tied to another provision of the Public Health Code which authorizes issuance of a "clinical academic license." Such a limited license allows a physician to practice as part of a medical school or hospital residency program without meeting the requirements for full licensure. MCL 333.16182(2)(c). The definition of "academic institution" logically mandates that a hospital must have a residency program in the specific field in which the physician with a clinical academic license will practice.[22]

Actually, the phrase "in a specialty area that includes the subspecialty of medical practice" undermines plaintiffs' and MTLA's position. This language treats a subspecialty as something which is *included within a specialty*. The common definition of "subspecialty" is "a narrow field of study or work within a specialty, as pediatric dermatology or geriatric psychiatry." *The American Heritage Dictionary of the English Language* (2000). The definition of the prefix "sub-" is "under, beneath, below . . . lower in rank, position, or importance than; inferior or subordinate to . . . so as to form a division into smaller or less important parts. . . ." *Webster's New World Dictionary* (1974).

In *Western Michigan University Bd of Control v State*, 455 Mich 531, 539-540, 565 NW2d 828 (1997), the issue was whether a university's renovation of its athletic facilities was a project "sponsored or financed in whole or in part by the state." This Court held that "Western Michigan University is 'the state' within the meaning of the prevailing wage act," finding that the unambiguous term "state" included "any part of state government." *Id* at 540. Applying this reasoning, "any part" of a specialty, *i.e.,* a subspecialty, is a "specialty."

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[22] MTLA is mistaken when it asserts that the definition of "academic institution" was already in effect then the Legislature originally enacted MCL 600.2169(1) in 1986. [MTLA Brief, p 17] The cited definition was added to MCL 333.17001(1) by 1990 PA 247, at the same time the provision authorizing clinical academic licenses was enacted in 1990 PA 248.

Plaintiff and MTLA also rely heavily on the Michigan Essential Health Provider Strategy Act ["MEHPSA"], MCL 333.2701 *et seq*. While the argument is not altogether clear, they seem to assert that the reference in MCL 333.2711(1) to "designated physician specialty areas" followed by a list of eight practice areas which are "board certified, or eligible for board certification" indicates that the Legislature intended to limit the "specialty" in MCL 600.2169(1) to areas of practice which are capable of primary board certification.[23]

This argument overlooks a fundamental inconsistency between MEHPSA and the RJA provisions applicable to malpractice actions. In the RJA, the Legislature has codified the traditional distinction between general practitioners and specialists, as to both expert qualifications, MCL 600.2169(1)(b) & (c), and standard of care, MCL 600.2912a(1)(a) & (b). However, MEHPSA refers to general practice as a "designated physician specialty area," MCL 333.2711(1). Describing "general practice" as a "specialty" is oxymoronic in the medical malpractice context.

E. Interpreting the term "specialty" according to its commonly understood meaning is consistent with prior decisions by this Court and the Court of Appeals.

This Court has already relied on the plain meaning of the term "specialty." *Cox*, *supra*, 467 Mich at 18. Other cases have applied this generally accepted understanding to specialized areas of medical practice without recognizing the dichotomy between specialties and subspecialties asserted by plaintiffs and MTLA.

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[23] Contrary to plaintiff's characterization, MEHPSA is not in *pari materia* with MCL 600.2169 and has nothing to do with "medical areas of qualifications for physicians." [Appellants' Brief, p 31, 34] Instead, it simply designates the physician specialty areas for which state and federal grants for tuition and loan repayments are available. MCL 333.2711.

MTLA is also wrong when asserting that MEHPSA was in effect when the Legislature enacted MCL 600.2169. [MTLA Brief, p 16] MEHPSA was added to the Public Health Code by 1990 PA 16.

In *Grossman v Brown*, 470 Mich 593, 685 NW2d 198 (2004), the issue involved the sufficiency of an affidavit of merit under MCL 600.2912d. The defendant physician was board certified in general surgery and held a certificate of special qualifications in vascular surgery. The affiant physician was "board certified in general surgery [and] specialized in vascular surgery." *Id* at 597. Plaintiff's counsel investigated the defendant's qualifications on the AMA site and was advised by the affiant physician that no board certification existed for vascular surgery. This Court held that the plaintiff's attorney had a reasonable belief that the affiant satisfied the requirements of MCL 600.2169. *Id* at 599-600.

If matching of ABMS and AOA primary specialties and board certifications were all that MCL 600.2912d and MCL 600.2169 required, then there would have been no need for this Court to even consider counsel's "reasonable belief" regarding the expert's qualifications. Both the defendant and affiant were board certified in the same primary specialty of general surgery. Under plaintiffs' and MTLA's interpretation, that match of primary specialty certifications would have satisfied MCL 600.2169(1). The issue decided by this Court only arose because the defendant and affiant did not have matching certifications in vascular surgery which was classified by ABMS (at that time) and AOA as a subspecialty of general surgery.

In *Halloran v Bhan*, 470 Mich 572, 683 NW2d 129 (2004), the defendant physician was board certified in internal medicine and held a certificate of added qualifications in critical care medicine. The proposed expert was board certified in anesthesiology with a certificate of added qualifications in critical care medicine. This Court held that MCL 600.2169(1) imposes two separate requirements for matching specialties and board certification. As in *Grossman*, there would not have been any need to consider the issue of matching board certifications if the term "specialty" did not include subspecialties. The matching "specialty" which satisfied the first

requirement was critical care medicine, even though it is classified as a subspecialty by the ABMS and AOA. The proposed expert was not qualified due to the second requirement for matching board certifications.

In *Tate v Detroit Receiving Hosp*, 249 Mich App 212, 642 NW2d 346 (2002), the physician involved in the patient's care specialized and was board certified in internal medicine, critical care medicine and nephrology. The proposed expert specialized and was certified in internal medicine. The Court of Appeals held MCL 600.2169(1) only "requires an expert witness to possess the same specialty as that engaged in by the defendant physician during the course of the alleged malpractice." *Id* at 220. The court found that the defendant's certifications in critical care and nephrology were irrelevant "because those specialties had nothing to do with the malpractice alleged by the plaintiff." *Id* at 221. If the statutory requirements were limited to primary specialties, there was no reason for the Court of Appeals to address the issue of matching multiple specialties. Both the defendant and expert specialized and were certified in internal medicine. The lack of matching specialties and certifications involved critical care medicine and nephrology, which are classified by the ABMS as subspecialties of internal medicine.

In *Nippa v Botsford Gen Hosp (On Remand)*, 257 Mich App 387, 668 NW2d 628 (2003), a malpractice action was brought against a hospital based on alleged negligence by two physicians who specialized and were board certified in infectious disease. The physician who signed the affidavit of merit specialized in infectious disease but was board certified in internal medicine and not infectious disease. The court held that the affidavit did not comply with MCL 600.2912d(1) because the affiant was not board certified in the same specialty as the health professionals on whose conduct the action is based. Under the ABMS classifications, the

practice of infectious disease is a subspecialty of internal medicine for which a certificate of special qualifications is issued.[24] *See also, Moy v Detroit Receiving Hosp*, 169 Mich App 600, 603, 426 NW2d 722 (1988)("infection disease specialist"); *Ravenis v Detroit General Hosp*, 63 Mich App 79; 234 NW2d 411 (1986)(same); *Golden v Baghdoian*, 222 Mich App 220, 222, 564 NW2d 505 (1997).

In *Sappanos v Brouwer*, unpublished opinion *per curiam* of the Court of Appeals, decided June 4, 1996 (Docket No. 164343), the defendant physician was board certified in internal medicine and the subspecialty of gastroenterology. The proposed expert was board certified in internal medicine and the subspecialty of infectious disease. Even though both gastroenterology and infectious disease are subspecialties of internal medicine, the majority affirmed the trial court's determination that the expert was not qualified under the previous version of MCL 600.2169(1).

Numerous cases have distinguished between general practitioners and specialists without making a further distinction between specialties and subspecialties. In *McClellan v Collar*, 240 Mich App 403, 613 NW2d 729 (2000), the court applied the earlier version of MCL 600.2169(1) and held that cardiology and cardiovascular surgery are related "specialties." Cardiology is not a primary specialty under the ABMS and AOA classifications; instead it is a subspecialty of internal medicine. *Mazey v Adams,* 191 Mich App 328, 330, 477 NW2d 698 (1991)("specialty in cardiology"); *Eggleston v Bio-Medical Applications of Detroit, Inc*, 248 Mich App 640, 642 645 NW2d 279 (2001)("specialist in nephrology"), *rev'd* 468 Mich 29, 658 NW2d 139 (2003).[25]

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[24] ABMS *Member Board Specialty and Subspecialty Certificates 2005* [Exhibit 1]

[25] See also, *Estate of Sawaya v Gottam*, unpublished opinion *per curiam* of the Court of Appeals, decided Feb. 21, 2003 (Docket No. 236394)(differentiating fields of internal medicine and gastroenterology); *Powell v Smith*, unpublished opinion *per curiam* of the Court of Appeals, decided Oct. 3, 1997 (Docket No. 193029)("critical care specialist"); *Waldorf v Azevedo*,

Plaintiffs assert that "'[s]pecialty' is a term of art used in the medical community, referring only to areas of medicine capable of being board certified." [Appellants' Brief, p 31] They offer no supporting authority for that proposition. However, the development of medical malpractice case law which led to the enactment of MCL 600.2169(1) in 1986 demonstrates that the term "specialty" was used in opposition to "general practitioner," *i.e.,* "a medical practitioner whose practice is not limited to any specific branch of medicine." *Cox, supra*, 467 Mich at 18 Nothing in the statute or the history of 1986 PA 78 suggests that the Legislature was intending to adopt a "term of art used in the medical community."

Defendants submit that *Hamilton v Kuligowski*, 261 Mich App 608, 684 NW2d 366 (2004), *lv gtd* 473 Mich 858, 701 NW2d 134 (2005), was wrongly decided. In that case, the defendant was board certified in internal medicine but devoted the majority of his practice to geriatrics. The expert was also board certified in internal medicine but spent the "vast majority of [his] clinical practice" on infectious disease. The Court of Appeals "decline[d] ...to graft a requirement for matching subspecialties onto the plain 'specialty' language of MCL 600.2169(1)." *Id*, 261 Mich App at 611-612. However, noticeably absent from the court's opinion is any analysis of the meaning of the "plain 'specialty' language." Specifically, the court did not even acknowledge this Court's interpretation of "specialist" as a physician who "deals only with a particular class of diseases, conditions, patients, etc." *Cox, supra*, 467 Mich at 18. See also, *Decker, supra*, 248 Mich App at 83. An infectious disease specialist deals with entirely different patients and conditions than a specialist in geriatrics.

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unpublished opinion *per curiam* of the Court of Appeals, decided Feb. 28, 1997 (Docket No. 188226)("cardiologists are specialists subject to their own unique standard of care"); *Walker v Hurley Medical Center*, unpublished opinion *per curiam* of the Court of Appeals, decided Nov. 5, 1996 (Docket No. 186576 & 186577)(referring to cardiology as a specialty).

In contrast, when the meaning of "specialist" was analyzed, a different panel of the Court of Appeals reached the opposite conclusion. In *McQuire v Wasvary*, unpublished opinion *per curiam* of the Court of Appeals, decided Jan. 25, 2005 (Docket No. 248309), the court noted that MCL 600.2169(1) "does not define or distinguish between specialist and subspecialists." Applying the definition of "specialist" cited in *Cox*, the court said that "there is no such distinction where a specialist is devoted to a subject or particular branch within a subject." *Id* p 6 n 4.

Halloran discusses a compelling reason for applying the generally accepted meaning of "specialty":

> Consider the facts of *this case*: there may be an enormous difference between critical care as practiced by an *internist* and critical care as practiced by an *anesthesiologist*. Indeed, one would expect that a patient requiring a medical diagnosis during critical care would rather be treated by an internist than an anesthesiologist. Likewise, one would expect that a patient being anesthetized during critical care would rather be treated by an individual trained in anesthesiology than one trained in internal medicine. Thus, the practice of critical care may be quite different depending on the physician's underlying specialization. *Id* at 579 n 7 (emphasis in original)

Presumably, the parents of a critically ill fifteen-day-old infant would want treatment by a physician specializing in the care of critically ill newborns, as opposed to a general pediatrician. And just as importantly, a jury would want to have the benefit of expert testimony from a physician with comparable expertise and experience in the specialized areas of pediatric critical care medicine and neonatology.

Dr. Custer treats a particular class of patients (newborn infants) and conditions (critical life-threatening illnesses and injuries). Applying the plain meaning of the statutory terms, neonatology and pediatric critical care medicine are "specialties." The trial court and Court of

Appeals correctly held that Dr. Casamassima was not qualified as an expert because he did not specialize in either of these areas of practice.

II. THE TERM "BOARD CERTIFIED" DESCRIBES A SPECIALIST WHOSE TRAINING, EXPERIENCE AND EXPERTISE HAVE BEEN VERIFIED BY A NATIONALLY RECOGNIZED SPECIALTY BOARD.

Dr. Custer's experience and expertise in pediatric critical care medicine and neonatology-perinatology have been certified by the American Board of Pediatrics. Because Dr. Casamassima did not have comparable certification from that board, he was not qualified to provide expert testimony under MCL 600.2169(1)(a).[26]

The term "board certified" is defined as "certified as expert: officially certified as expert in a particular field after passing an exam and meeting strict standards." *Encarta World English Dictionary* (1999). This is consistent with the common understanding of the term "certified," *i.e.*, "endorsed authoritatively: guaranteed or attested as to quality, qualifications, fitness or validity." *Webster's Third New International Dictionary* (1976). A widely used medical dictionary defines "certification" as an "acknowledgment by a medical specialty board of successful completion of requirements for recognition as a specialist." *Stedman's Medical Dictionary* (27th ed 2000).

Applying the dictionary definition of "board certified" furthers the legislative intent of MCL 600.2169(1). When a recognized board has formally verified a physician's training, experience and expertise in a specialized area of medicine, expert testimony should come from a physician with comparable credentials. Just as board certification attests to a physician's

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[26] As discussed in Argument I, the trial court's exclusion of Dr. Casamassima's testimony can be affirmed based on the lack of specialty matching. Regardless of this Court's interpretation of the term "board certified," plaintiffs failed to present an expert who met the first requirement of MCL 600.2169(1)(a). *Halloran, supra.*

experience with treating patients in a specialized area, it also verifies the qualifications of expert witnesses who will either support or criticize the care provided to those patients.[27]

This Court has directed the parties to brief whether the term "board certified" includes "certificates of special qualifications." At the outset, it is important to note that various specialty boards use different terminology to describe subspecialty certification. Some refer to "certification in the subspecialty" and "subspecialty certificates"[28]; others describe their certifications as "certificates of special qualifications" or "certificates of added qualifications." Some boards issue both "subspecialty certificates" and "certificates of added qualifications."[29] And in many cases, the boards use these terms interchangeably to describe the certification of physicians with additional training and verified expertise in their areas of practice.[30] The lack of

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[27] In a policy statement, the ABMS stated that "[t]he intent of the certification of physicians is to provide assurance to the public that a physician specialist . . . has successfully completed an approved educational program and an evaluation process which includes an examination designed to assess the knowledge, skills, and experience required to provide quality patient care in that specialty." ABMS, *The Purpose of Certification* [Exhibit 11, p 1]

[28] American Board of Psychiatry and Neurology, *2005 Information for Applicants for Certification in the Subspecialty of Pain Medicine*, p 5-6 [Exhibit 12]; American Board of Pathology, *Certification by the ABP*. [Exhibit 13]

[29] American Board of Internal Medicine, *Policies and Procedures for Certification*, July 2005, p 5. [Exhibit 10]

[30] In one document, the American Board of Pediatrics states that it "awards certificates in General Pediatrics and in the following subspecialty areas." ABP, *The American Board of Pediatrics,* p 1 [Exhibit 14] In another, the ABP indicates that it issues "a certificate of special qualifications in the following subspecialties." ABP, *Certification in the Pediatric Subspecialties*, p 1 [Exhibit 15] The AOA defines a "certificate of special qualifications" as "[s]ubspecialty certification conferred by a certifying Board in a specific subspecialty area of the field to which that Board certifies." [Exhibit 16]

any consistent terminology is most evident in the ABMS' reference to "specialty certification in a subspecialty field."[31]

As noted in Argument I, the terminology used by the Legislature in various statutes has been similarly inconsistent. MCL 333.2711(1) refers to board certification in general practice, which is not a specialty. MCL 333.16204a(1)(a) and MCL 550.1402a(2)(b) require board certification in pain medicine, which is a subspecialty.

As with any question of statutory interpretation, it is always best to look at the common dictionary definition of terms to discern legislative intent. The definition of "board certified" as "officially certified as expert in a particular field after passing an exam and meeting strict standards," *Encarta World English Dictionary* (1999), focuses on the official recognition of a physician's training and expertise in a specialized area of medicine. The classification of practice areas and the terminology used to describe certification by the various specialty boards are not determinative. Instead, the Legislature used a broad term that encompasses the various descriptions used by the boards when certifying physicians as experts in specific areas of practice.

This interpretation is consistent with the legislative purpose of MCL 600.2169(1). As with the requirement of specialty matching, the Legislature intended that expert testimony regarding a physician's compliance with or breach of the standard of care should come from a peer with the same level of training, experience and expertise. As discussed in Argument I(B), *supra*, importing the ABMS and AOA practice area classifications into the definition of "specialty" would undermine the legislative intent and lead to absurd results. The same concerns would arise from attempting to define "board certified" by overlaying the certification

[31] American Board of Medical Specialties, *The Significance of Certification in Medical Specialties*, p 6 [Exhibit 11]

terminology used by ABMA and AOA. Any effort to reconcile the various descriptions of the certificates issued by the specialty boards does nothing to further the legislative purpose.

Plaintiffs and MTLA rely on the definition of "board certified" set forth in the MEHPSA, *i.e.,* "certified to practice in a particular medical specialty by a national board recognized by the American board of medical specialties or the American osteopathic association." MCL 333.2701(a). A number of other statutes also refer to physicians certified by the ABMS, AOA, the Accreditation Council on Graduate Medical Education, the American Board of Medical Genetics, the American Board of Pain Medicine and other professional associations. See, *e.g.*, MCL 550.2212a(4); MCL 333.9709(3)(a); MCL 333.20918(3); MCL 333.17020(3) & 333.17520(3); MCL 333.16204a.

These statutes demonstrate that the Legislature was fully capable of identifying certain specialty boards when setting forth certification requirements for physicians. The omission of any such language in MCL 600.2169(1) must be presumed to be intentional. *Farrington, supra,* 442 Mich at 210. By using the term "board certified" without any further specification to establish the qualifications for expert witnesses, the Legislature intended to ensure that the expertise and experience of these critical witnesses have been verified by an independent certifying board. Whether that verification is evidenced by a specialty certification, subspecialty certification, certificate of special qualifications or certificate of added qualifications is not the relevant consideration. The legislative goal is ensuring that an expert actually has relevant expertise.

MTLA raises the specter of two doctors who "designate themselves as 'Bay City Board of Seventh Avenue Proctologists' and confer upon themselves some 'subspecialty' designation." [MTLA Brief, p 13] This overwrought fantasy would require a court to disregard the plain

meaning of "specialist" as "a medical practitioner who devotes attention to a particular class of diseases, conditions, patients, etc." The "particular class" of diseases and conditions in this example are those involving the rectum and anus, *i.e.,* those within the scope of proctology. Nothing in any definition of "specialist" or "specialty" suggests any geographic limitation.

Both the ABMS and AOA have standards for the recognition of subspecialties which eliminate any concern about Balkanization of medical practice. When a member board requests authorization to certify a subspecialty, the ABMS requires review of the proposals by the Committee on Certification, Subcertification and Recertification, by the Executive Committee, and by the full membership of the ABMS.[32] Only those subspecialties which are recognized and needed by the medical community are approved.

When applying the requirements of MCL 600.2169(1), a trial court would have to determine whether there is a "specialty" which is "board certified." A court could certainly consider whether a nationally recognized board such as the ABMS or AOA has determined that

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[32] ABMS, *The Significance of Certification in Medical Specialties* [Exhibit 11, p 9] An ABMS policy statement confirms that the "purpose of subspecialty certificates is to establish standards of preparation to be required of those individuals who wish to provide care to the public *in a subspecialty area that the ABMS has determined is of sufficient importance to be so designated.*" [*Id* , p 10 (emphasis added)]

A request for a new or modified subspecialty certificate must include, *inter alia*, documentation of the professional and scientific status of the special field, the number and names of institutions providing residency and educational programs in the specialty, the total number of positions available, and the number of trainees completing training annually. A statement is submitted projecting the needs for and the effect of the new certification on the existing patterns of specialty practice, including quality of care and advantages to the public. American Board of Pain Medicine, *ABPN Recognition of Subspecialties.* [Exhibit 17]

The Accreditation Council for Graduate Medical Education imposes similar standards, requiring "the existence of a body of scientific medical knowledge underlying the subspecialty that is in large part distinct from, or more detailed than, that of other areas in which accreditation is already offered" and "the existence of a sufficiently large group of physicians who concentrate their practice in the proposed subspecialty area." Accreditation Council for Graduate Medical Education, *Policies and Procedures, July 1, 2005*, p 24-26 [Exhibit 18]

an area of practice is sufficiently distinct to warrant separate certification requirements. The two proctologists from Bay City would not be able to meet these standards.

MTLA also relies on thirty-year-old information about the number of board certified physicians, along with an artificial breakdown by specialty, in an effort to suggest that applying the plain meaning of "specialty" and "board certified" would unreasonably limit the number of potential expert witnesses.[33] In a comment that actually provides a compelling argument for rejecting its interpretation, MTLA points out that the Legislature has "restricted testimonial qualifications to the most knowledgeable" physicians. [MTLA Brief, p 29] Defendants wholeheartedly agree.

The plain meaning of "board certified" includes the certification of a physician's training and expertise in a specialized area of practice by a recognized professional board. Nothing in the statute suggests that the Legislature intended to have the classifications and terminology used by the ABMS, AOA or any other association, override the generally accepted meaning of "board certified." The American Board of Pediatrics has imposed rigorous and demanding requirements for any physician like Dr. Custer who wants to specialize in the care of critically ill infants and newborns.[34] Certification in a broad field such as pediatrics does not demonstrate that a proposed witness has expertise and experience in highly specialized areas such as pediatric critical care medicine or neonatology.

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[33] According to more recent information, the ABMS has awarded 803,947 specialty certificates through the end of 2004. *2005 ABMS Annual Report and Reference Handbook*, Table 2 [Exhibit 19]

[34] The requirements for certification in pediatric critical care medicine and neonatology-perinatology are detailed in American Board of Pediatrics, *Certification in the Pediatric Subspecialities*. [Exhibit 15]

III. THE PLAIN MEANING OF "SPECIALTY" SHOULD GOVERN THE INTERPRETATION OF MCL 600.2169(1)(b). AN EXPERT WITNESS MUST PRACTICE IN OR TEACH THE SAME SPECIALTY AS THE DEFENDANT, REGARDLESS OF WHETHER THAT SPECIALIZED AREA OF MEDICAL PRACTICE IS CLASSIFIED AS A SPECIALTY OR SUBSPECIALTY BY THE ABMS OR AOA.

The "active clinical practice" or "instruction of students" requirement of MCL 600.2169(1)(b) employs the same terms as MCL 600.2169(1)(a), *i.e.,* "specialist" and "specialty." The plain meaning of those terms, as discussed in Argument I, *supra*, should govern the interpretation of this subsection as well. "It is reasonable to conclude that words used in one place in a statute have the same meaning in every other place in the statute." *Little Caesar Enterprises v Dep't of Treasury*, 226 Mich App 624, 630, 575 NW2d 562 (1997); *Peiffer v General Motors Corp*, 177 Mich App 674, 677, 443 NW2d 178 (1989).

Accordingly, the correct focus is whether the defendant physician specializes in the treatment of a "particular class of diseases, conditions, patients, etc." *Cox*, *supra*, 467 Mich at 18. The designation of specialized practice areas as specialties or subspecialties by the ABMS and AOA is not determinative. The statutory requirement of recent practical experience in a defendant's specialty closely parallels those of equivalent specialization and board certification. All three requirements further the legislative intent of ensuring that an expert has "firsthand practical experience in the subject matter." *McDougall*, *supra*, 461 Mich at 25 n 9.

IV. THE RELEVANT SPECIALTIES INVOLVED IN THE ALLEGED MALPRACTICE ARE PEDIATRIC CRITICAL CARE MEDICINE AND NEONATOLOGY. PLAINTIFFS' PROPOSED EXPERT DID NOT SPECIALIZE, WAS NOT BOARD CERTIFIED, AND HAD NO ACTIVE CLINICAL PRACTICE IN THESE SPECIALTIES.

A. The relevant specialties are pediatric critical care medicine and neonatology.

Austin Woodard was born on January 15, 1997. On January 29, the infant was seen by his general pediatrician for respiratory distress. On the following day, January 30, he was having

"trouble breathing" and was "choking" and "congested." His pediatrician suspected RSV bronchiolitis, a life-threatening respiratory disease that attacks infants. The infant was sent to the emergency room at University of Michigan Hospital by ambulance with oxygen. [Dr. Kennedy's Records – Appx 8a-9a]

Upon arrival at the emergency room, Austin was cyanotic and in significant respiratory distress. After being stabilized, he was transferred to the PICU. Shortly afterwards, he was intubated due to significant apnea. [Interim Summary – Appx 118b; Procedure Note 1/30/97 – Appx 114b] He was "so sick he required mechanical ventilation...and was instrumented and an artificial air hose was placed." [Custer Dep p 15-16 – Appx 100a]

Austin remained in the pediatric intensive care unit until February 9, 1997. During that entire time, he was intubated to provide respiratory assistance. [*Id*] He was sedated and received feeding through a feeding tube. An arterial line was placed in his right groin. A central venous catheter was placed in his left groin area. At all times while the infant was in the intensive care unit, the attending physicians were specialists in pediatric critical care medicine. The residents were fellows training in that specialty. [Custer Dep p 73 – Appx 115a] Austin was a neonate, *i.e.,* an infant less than 28 days old, during his treatment in the PICU.[35]

The complaint alleges that Dr. Custer, who is described as a "specialist in critical care medicine," and the other physicians in the PICU failed to properly place and monitor the arterial, venous and femoral lines, failed to timely diagnose and treat the infant's conditions and symptoms, negligently discharged the infant from the PICU, and failed to issue timely orders and instructions for observations of the infant while in the PICU. [Complaint ¶ 19, 53 – Appx 47a, 55a-56a] The affidavit of merit signed by Dr. Casamassima expounded on these alleged

[35] A "neonate" is "an infant aged 1 month or less." *Stedman's Illustrated Medical Dictionary*, (27th ed 2000)

violations of the standard of care by the pediatric critical care physicians in the PICU. [Affidavit of Merit – Appx 61a-63a] In his deposition, Dr. Casamassima detailed his criticisms of the care provided by these specialized physicians while Austin was critically ill in the PICU.

As discussed previously, Dr. Custer has devoted his professional life exclusively to the care and treatment of critically ill children, including neonates, as well as teaching critical care medicine as director of the pediatric critical care fellowship program. He is certified by the American Board of Pediatrics in pediatrics, pediatric critical care and neonatology-perinatology. He has been the director of the pediatric critical care unit at Mott Children's Hospital since 1985. [Custer Dep Tr p 3-5 – Appx 97a-98a]

This case is about Austin Woodard, a desperately ill newborn who required and received highly specialized care from pediatric critical care medicine specialists in the pediatric intensive care unit at a major hospital. The alleged malpractice relates to the care and treatment provided by Dr. Custer and the other pediatric intensivists in the PICU. Pediatric critical care medicine and neonatology are the relevant specialties.[36]

Plaintiffs argue that their "theory is the fractures of Austin's legs occurred during *general pediatric maneuvers*." [Appellants' Brief, p 22 (emphasis in original)] They assert that "[t]he evidence supports that the broken legs occurred because of misapplied force or mishandling during *general pediatric* maneuvers." [*Id* at 23 (emphasis in original)] This effort to recharacterize their complaint relating to the care provided by pediatric critical care medicine

[36] The word "critical" is defined as "[d]enoting or of the nature of a crisis," and "[d]enoting a morbid condition in which death is possible." *Stedman's Medical Dictionary* (27th ed 2000). Neonatology is "the art and science of diagnosis and treatment of disorders of the newborn infant." "Neonatal" is defined as "pertaining to the first four weeks after birth." *Dorland's Illustrated Medical Dictionary* (27th ed 1988).

specialists to a critically ill neonate in the pediatric intensive care unit of a hospital fails for several reasons.

First, there is no evidence that the fractures occurred during "general pediatric maneuvers." In his deposition, Dr. Casamassima admitted:

> ...all I know about Austin Woodard or fractures – all I can say with certainty is that he didn't come into the hospital with them. While he was in the hospital, they were discovered. There were a number of procedures performed on him which had the potential to allow for the fracture of the femurs bilaterally. What actual procedure or actual event caused the fracturing of the femurs, it's impossible to tell from this record. [Casamassima Dep p 7-8 – Appx 129a]

This simply restates the *res ipsa loquitur* argument which this Court has already rejected. *Woodard v Custer*, 473 Mich 1, 702 NW2d 522 (2005).

Second, there was no testimony that the procedures identified by Dr. Casamassima are performed by general pediatricians as opposed to specialists in pediatric critical care medicine. Intubation and placement of arterial and venous lines are medical procedures performed in the hospital for the care of critically ill patients. The Court of Appeals concluded:

> [Dr. Casamassima] *did not assert that those procedures were normally practiced in general pediatrics or that the standard of care for the treatment of critically ill infants was the same as that for general pediatric practice.* Rather, he opined that the standard of care for the PICU was grounded in the policies and procedures established for those medical procedures – but he expressly testified that he did not know what the policies and procedures were. *Accordingly, plaintiffs' theory of the case was grounded not in general pediatric treatment but in pediatric intensive care.* [Opinion (Talbot, J.) p 5 – Appx 233a (emphasis added)]

Third, plaintiffs confuse the separate requirements for expert testimony regarding standard of care and causation. In *Halloran, supra*, 470 Mich at 578 n 6, this Court noted that "MCL 600.2169(1) deals only with expert witnesses regarding the standard of care." An expert

on causation must be qualified under MCL 600.2169(2). Dr. Casamassima's speculation about the possible causes of the fractures is not relevant in determining whether he is qualified to testify that Dr. Custer and the other physicians in the PICU breached the standard of care in their care and treatment of a critically ill newborn.

The relevant focus is the specialty being practiced by the physician when he or she allegedly breached the standard of care, not the particular procedure which was performed. In *McDougall, supra*, 461 Mich at 22-23, 37, this Court held that a physician who was board certified in internal medicine and gastroenterology was not qualified to testify against a board certified colorectal surgeon, despite testimony that "internists and surgeons *follow the same standards of care* for the diagnosis of gastrointestinal problems and *for performance of diagnostic procedures such as sigmoidoscopy*." (emphasis added) Thus, plaintiffs' attempt to equate the procedures performed by general pediatricians and pediatric critical care specialists does not substitute for Dr. Casamassima's lack of practice, specialization or certification in pediatric critical care medicine or neonatology.

The statute's emphasis of the specific area of medical practice being performed by the physician is also recognized in *Halloran, supra*, 470 Mich at 577 n 5. This Court said that "the defendant physician was *practicing internal medicine*, not anesthesiology, *when he committed the alleged malpractice*" and therefore, his "internal medicine board certification is a 'relevant' board certification." (emphasis added) In *Tate, supra*, 249 Mich App at 220, the Court of Appeals concluded that MCL 600.2169(1) only "requires an expert witness to possess the same *specialty as that engaged in by the defendant physician* during the course of the alleged malpractice." In determining the relevant specialty under the facts of that case, the court noted

plaintiff's allegation that the patient "*was receiving general care* and not critical care or the care of a nephrologist" when the urinary tract infection was not diagnosed. (emphasis added)

The focus of MCL 600.2169(1) on the specialty practiced by the defendant physician rather than the particular procedure is further demonstrated by comparison to the prior version of the statute. The original statute enacted in 1986 required that an expert specialize in and devote a substantial portion of professional time to "the same specialty or a related, relevant area of medicine or osteopathic medicine and surgery or dentistry..." In *McClellan v Collar*, 240 Mich App 403, 613 NW2d 729 (2000), the Court of Appeals relied on testimony that both cardiologists and cardiovascular surgeons are involved in the preoperative and postoperative care of aortic valve replacement patients. Because the allegation against the surgeon related to the improper performance of valve replacement surgery, the court held that cardiology and cardiovascular surgery were "related" and "relevant" areas of medicine. The court noted that the language of the prior statute did not "require experts to be specialists in the exact fields practiced by defendants against whom they are going to testify." *Id* at 412. In contrast to the original statute, the current version of MCL 600.2169(1) explicitly requires an exact match of specialties. A showing that the same procedure is performed by physicians in related areas of practice is not sufficient.

Whether a general pediatrician can intubate a patient or insert an arterial line is not the relevant question. Any licensed physician – whether a general practitioner or a specialist – can lawfully perform any medical procedure. Specialization and certification are voluntary steps.[37] When a malpractice action is brought against a specialist, the issue is whether the physician breached the standard of care applicable to that specialty. MCL 600.2912a(1). In this case,

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[37] ABMS, *The Significance of Certification in Medical Specialties*, p 10 [Exhibit 11]

plaintiffs were required to present a qualified expert to support their allegations that Dr. Custer breached the standard of care required of specialists providing care to critically ill newborns in a pediatric intensive care unit. The Court of Appeals correctly concluded that Dr. Casamassima was not familiar with the standard of care for the treatment of critically ill infants.

Finally, plaintiffs' theory that the fractures resulted from "mishandling" during "general pediatric maneuvers" was never asserted in the trial court. The complaint alleged that Dr. Custer was a specialist in "critical care medicine." [Complaint ¶ 14, 19 – Appx 46a-47a] Plaintiffs alleged that the "applicable standard of care" required Dr. Custer and the other physicians to exercise the proper degree of care and caution "when treating a *newborn* in the placement and monitoring of an arterial line, venous line, femoral line, and intubation for apnea." [*Id* ¶ 48 – Appx 53a (emphasis added)] In responding to the motion challenging their expert's qualifications, plaintiffs relied on the *res ipsa loquitur* doctrine and asserted that Dr. Casamassima's background in general pediatrics was sufficient to allow an opinion that fractures should not occur in the hospital. [Motion hearing 9/14/01 Tr p 18-23 – Appx 178a-183a]

Rather, this revised theory of the case was only raised after the release for publication of the Court of Appeals' decision in *Tate* on January 15, 2002. (The trial court ruled that Dr. Casamassima was unqualified on September 14, 2001.) In any event, *Tate* provides no support for this belated argument. In that case, the court held that internal medicine, as opposed to critical care medicine, was the relevant specialty because the alleged malpractice occurred *after the patient had been transferred out of the critical care unit. Tate, supra*, 249 Mich App at 220 n 2. The treatment provided by Dr. Custer was an integral part of the care provided to the infant in the PICU. The Court of Appeals correctly concluded that plaintiffs' claims "rested in the area of pediatric critical care medicine."

B. Dr. Casamassima was not qualified to give expert testimony as to the standard of care in the specialties of pediatric critical care medicine or neonatology.

Dr. Casamassima failed to meet any of the three requirements imposed by MCL 600.2169(1).

He does not specialize in pediatric critical care medicine or neonatology. He is not certified in either field by the American Board of Pediatrics.

The trial court made detailed factual findings as to Dr. Casamassima's lack of any clinical experience in the specialized areas of practice involved in the care and treatment of the critically ill newborn in the pediatric critical care unit:

> • Between December 1993 and March of 1998, none of Dr. Casamassima's clinical practice involved pediatric critical care medicine;
>
> • Dr. Casamassima has no experience or training as an attending physician in a pediatric intensive care unit;
>
> • The last time he performed an intubation or inserted arterial or venous lines was during his residency in the early 1980's. [Tr 9/14/01, p 30-31 – Appx 190a-191a]

Based on these findings, the trial court concluded that Dr. Casamassima was not qualified under MCL 600.2169(1)(b) because he "did not devote a majority of his time within the year preceding the injury to the same active clinical specialty as Dr. Custer or the staff of the pediatric intensive care unit." [Tr 9/14/01, p 31 – Appx 191a]

Plaintiffs have not disputed any of the factual findings. Instead, they assert that the trial court improperly "focused on the nature of Dr. Casamassima's practice and profession *after* March 1998, and the time he currently spends running the Richmond Children's Center." [Appellants' Brief, p 44 (emphasis in original)] A review of the findings demonstrates that argument is simply wrong. Other than the reference to Dr. Casamassima becoming a full-time

attorney in March of 1998, the findings relate to the nature of his practice from 1993 to 1998 and his lack of any experience or training in the relevant specialties.

Plaintiffs note that Dr. Casamassima had exposure during his residency in the early 1980's to intubation and venous and arterial line placement, and argue that if "a general pediatric resident performs [these tasks] during residency, they certainly cannot be characterized as unique to pediatric critical care medicine." [Appellants' Brief, p 23] However, the statute does not determine an expert's qualifications based on familiarity with particular medical procedures. The plain language requires an expert to devote a majority of his or her recent professional time to the same specialty as the defendant. The procedures performed during Dr. Casamassima's residency over a quarter-century ago are simply irrelevant.

The Court of Appeals properly affirmed the trial court's ruling that Dr. Casamassima was not qualified to testify under MCL 600.2169(1).

C. MCL 600.2169(1) requires an expert to match the specialties and certifications relevant to the alleged act of malpractice.

In *Tate*, *supra*, 249 Mich App at 219-220, the Court of Appeals held that MCL 600.2169(1) only "requires an expert witness to possess the same specialty as that engaged in by the defendant physician during the course of the alleged malpractice." The court stated that the statute "cannot be read or interpreted to require an exact match of every board certification held by a defendant physician. Such a 'perfect match' requirement would be an onerous task and in many cases make it virtually impossible to bring a medical malpractice case."

This Court has directed the parties to address "[w]hether MCL 600.2169(1) requires an expert witness to match all specialties, subspecialties, and certificates of special qualifications that a defendant may possess, or whether the expert witness need only match those that are relevant to the alleged act of malpractice."

As a preface, defendants emphasize that plaintiffs' proposed expert was not a specialist or board certified in *either* of the relevant specialties involved in the care and treatment of Austin Woodard in the PICU. Therefore, defendants respectfully submit that resolution of the question posed by this Court is neither necessary nor dispositive under the facts of this case. Interpreting the statute to require matching of relevant specialties and certifications would suffice to affirm the Court of Appeals.

MTLA asserts that MCL 600.2169(1) "refers to a single 'specialty', not multiple specialties." It maintains that the statutory language, *i.e.,* that an expert must "specialize . . .in *the same specialty* as the party" and engage in "active clinical practice of *that specialty*," requires the conclusion that matching only one specialty is necessary. [MTLA Brief, p 31-32 (emphasis added)] While not expressly stated, this position inevitably leads to the argument that only one specialty must be matched, even if more than one specialty is relevant to the alleged malpractice.

MTLA's argument is contrary to the statutory directive that "[e]very word importing the singular number only may extend to and embrace the plural number..." MCL 8.3b. While this construction is not mandatory, it should be observed unless doing so "would be inconsistent with the manifest intention of the legislature." MCL 8.3; *Robinson v Detroit*, 462 Mich 439, 461 n 18, 613 NW2d 307 (2000); *Casco Twp v Secretary of State,* 472 Mich 556, 598, 701 NW2d 102 (2005) (Young, J., *concurring in part and dissenting in part*). Where the alleged malpractice involves more than one specialized area of medicine, requiring an expert to have "firsthand practical experience" in the relevant specialties is hardly "inconsistent with the manifest intention of the legislature." To the contrary, MCL 600.2169(1) expresses the Legislature's determination that experts should have practical experience in the subject matter. *McDougall, supra,* 461 Mich at 509, n 1.

In this case, the specialized knowledge of both pediatric critical care medicine and neonatology were involved in the treatment of a critically ill fifteen-day-old infant.[38] The trial court and Court of Appeals correctly held that a proposed expert with no experience in *either* specialty was not qualified under MCL 600.2169(1).

CONCLUSION

Defendants-Appellants Joseph R. Custer, M.D. and University of Michigan Medical Center request that this Court affirm the holding by the Court of Appeals that the trial court correctly held that plaintiffs' proposed expert witness was not qualified under MCL 600.2169(1).

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[38] If this Court determines that only one "specialty" must be matched, defendants submit that the most relevant specialty is pediatric critical care medicine. As the Court of Appeals found, "plaintiffs' theory of the case was grounded" in that specialty. [Opinion (Talbot, J.) p 5 – Appx 233a]